



Documentation of Vital Signs

Policy:

Every patient encounter by EMS will be documented. Vital signs are a key component in the evaluation of any patient and a complete set of vital signs is to be documented for any patient who receives some assessment component.

Purpose:

To insure:

- Evaluation of every patient's volume and cardiovascular status
- Documentation of a complete set of vital signs

Procedure:

1. An **initial** complete set of vital signs includes:
 - Pulse rate
 - Systolic **AND** diastolic blood pressure
 - Respiratory rate
 - Pain / severity (when appropriate to patient complaint)
 - GCS for Injured Patients
2. When no ALS treatment is provided, palpated blood pressures are acceptable for **REPEAT** vital signs.
3. Based on patient condition and complaint, vital signs may also include:
 - Pulse Oximetry
 - Temperature
 - End Tidal CO₂ (If Invasive Airway Procedure)
 - Breath Sounds
 - Level of Response
4. If the patient refuses this evaluation, the patient's mental status and the reason for refusal of evaluation must be documented. A patient disposition form must also be completed.
5. Document situations that preclude the evaluation of a complete set of vital signs.
6. Record the time vital signs were obtained.
7. Any abnormal vital sign should be repeated and monitored closely.